Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Xolair Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F. (609)228-9798 Attn: Idyllic Infusion Coordinator

Is this a Continuation of Care or a new start to the medication?

- ▢ Continuation of Care (Provide documentation of last administration)
- ▢ New Rx

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI Tax ID#	**Name: NPI: Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s): include copies of front and back	

Preferred Treatment Location	▢ Voorhees ▢ Wall/Manasquan ▢ Hamilton	▢ Moorestown ▢ Sewell ▢ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:	

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Diagnosis:

▢ J45.40 Moderate persistent asthma, uncomplicated
▢ J45.41 Moderate persistent asthma w/acute exacerbation
▢ J45.42 Moderate persistent asthma w/ status asthmaticus
▢ J45.50 Severe persistent asthma, uncomplicated
▢ J45.51 Severe persistent asthma w/acute exacerbation
▢ J45.52 Severe persistent asthma w/status asthmaticus
▢ L50.1 Idiopathic urticaria
▢ Other: _____

Allergy Note: Xolair prefilled syringe caps may contain latex. If patient has an allergy to latex, order Xolair for reconstitution without latex.

The following information is required for authorization for persistent allergic asthma:

- Is the patient's asthma reversible? ▢ YES ▢ NO
  - Please provide details such as documented PEF response to short-acting inhaled beta-1 agonists.

- Is the patient refractory or symptomatic to the following:
  - at least 1 month trial of a second-generation H1-antihistamine, **AND**
  - refractory or symptomatic to at least 1 month trial of up-dosing (up to 4-fold) of an H1-antihistamine (2nd gen), **OR** add-on therapy with a leukotriene antagonist, another H1-antihistamine, an H2-antagonist or cyclosporin-A? ▢ YES ▢ NO

- Is the patient symptomatic, or inadequately controlled, after at least 3 months of prior combination therapy, including inhaled corticosteroids plus another controller medication? ▢ YES ▢ NO

- Does the patient use tobacco? ☐ YES ☐ NO

- Will Xolair be used concurrently in combination with Fasenra, Nucala or Cinqair? ☐ YES ☐ NO

The following information is required for authorization for chronic idiopathic urticaria:

- Recent lab results of the baseline serum IgE levels.
- Documented evidence of specific allergic sensitivity.
- Documentation of baseline evaluation of quality-of-life instruments including UAS7, DLQI, CU-Q2oL, AAS or AE-QoL score.

- Will Xolair be used concurrently in ombination with Fasenra, Nucala or Cinqair? ☐ YES ☐ NO

- Does this patient require premedication(s)? ☐ YES ☐ NO
  - If so, which pre-medications are required?
    - _____

- Is this patient ambulatory ?
  - If no, is a wheelchair required? ☐ YES ☐ NO

PLEASE NOTE:

- Please attach a copy of medication order when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX are required.
  - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** Please notify our office if the medication is discontinued.

☐ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature:

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